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Office of Administrative Law Judges
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Issue Date: 14 December 2006

In the Matter of:

Mrs. V.F., widow of
Mr. J.C.F.,¹
Claimant

Case No.: 2005 BLA 5857

v.

FREEMAN UNITED COAL MINING CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS

Party in Interest

Appearances: Mr. Darrell Dunham, Attorney
For the Claimant

Ms. Christina B. Conlin, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER –
DENIAL OF MODIFICATION REQUEST**

This matter involves a claim filed by Mrs. V.F., widow of Mr. J.C.F., for survivor benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

¹Despite 20 C.F.R. § 725.477(b) (“A decision and order shall contain . . . the names of the parties . . .”), and over my specific objection, Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

Procedural Background

Mr. F.'s Black Lung Disability Claims

Initial Claim (DX 1)²

On April 7, 1977, Mr. F. filed his first claim for black lung disability benefits. On March 7, 1979, a claims examiner awarded benefits to Mr. F. The Employer controverted liability on March 19, 1979, and an informal conference was held on July 24, 1979. The Memorandum of Conference was issued August 3, 1979, finding that Mr. F. was entitled to benefits and initiating payments from the Black Lung Trust Fund, augmented for Mr. F.'s spouse, Mrs. F. On September 28, 1979, the Department of Labor ("DOL") wrote to Mr. F. to inform him that no rejection was received from the Employer, but a formal hearing would follow. On October 26, 1979, Mr. F. replied, arguing that without a rejection of the Memorandum's findings from the Employer, the findings became final. On October 26, 1979, the DOL referred the claim to the Office of Administrative Law Judges ("OALJ").

An administrative law judge ("ALJ") held a hearing in Marion, Illinois on March 28, 1980. Mr. F. objected at the hearing, arguing that the Employer never contested issues and thus an appeal was unwarranted. The Employer responded that they did not receive the Memorandum but that they contested the issues during the conference. The ALJ overruled the objection. The ALJ denied benefits on July 18, 1980 because the presumption of total disability based on 10 or more years of coal mine employment was rebutted by the Employer. Mr. F. filed a petition for review before the Benefits Review Board ("BRB") on September 23, 1980, arguing that the Employer did not reject the conference findings in a timely manner. In a published decision on July 28, 1981, the BRB affirmed the ALJ's decision and found that the Employer was not sent a copy of the Memorandum but the rejection of its findings was implied by the Employer's arguments at the conference.

Second Claim (DX 1)

On October 24, 1983, Mr. F. filed a second claim. The District Director denied the claim on May 9, 1984, for failure to show coal workers' pneumoconiosis or total disability. On May 22, 1984, Mr. F. requested a formal hearing before OALJ. On February 13, 1987, the DOL sent a letter to Mr. F. confirming a phone call in which Mr. F. said he didn't want to pursue the claim and informing Mr. F. that his claim was being closed.

²The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; TR – Transcript; and, ALJ – Administrative Law Judge exhibit.

Third Claim
(DX 1)

On October 16, 1992, Mr. F. filed his third claim. The District Director determined that Mr. F. had coal workers' pneumoconiosis but was not totally disabled due to it, and denied the claim on June 30, 1993. Mr. F. requested a formal hearing before OALJ on July 7, 1993. The District Director referred the claim to OALJ on October 4, 1993. An ALJ held a hearing on May 25, 1994 in Carbondale, Illinois. Mr. F. passed away on June 22, 1994, and Mrs. F. took over the claim. The ALJ denied Mr. F.'s claim on February 23, 1995 for failure to show total disability due to pneumoconiosis, and Mrs. F. appealed to the BRB on March 20, 1995. The BRB affirmed-in-part, vacated-in-part, and remanded to the ALJ. On November 20, 1995, the Employer filed a motion for reconsideration before the BRB, which the BRB granted on April 10, 1996, remanding the case to the ALJ for additional proceedings. On October 9, 1996, the ALJ denied benefits for failure to show total disability.

Mrs. F.'s Survivor Claim

Mrs. F. filed a survivor claim for benefits on August 20, 2002 (DX 5). The District Director denied the claim on March 21, 2003, because although Mrs. F. was able to show that Mr. F. had coal workers' pneumoconiosis, she did not show that his death was due to pneumoconiosis (DX 21). Mrs. F. requested a formal hearing on April 22, 2003 (DX 22), and the District Director referred the case to OALJ on July 31, 2003 (DX 26). An ALJ held a hearing on March 9, 2004 in Murphysboro, Illinois. Although Mrs. F. and another witness testified, Mrs. F. did not provide other evidence. The ALJ left the record open for 60 days for the submission of evidence. On May 11, 2004, Mrs. F.'s former attorney filed a Motion to Dismiss, stating "the Claimant doses [sic] not desire to pursue her Black Lung Claim." On June 2, 2004, the ALJ granted the dismissal.³

On January 20, 2005, Mrs. F. sent a letter to the DOL, stating that her attorney was not authorized to request the dismissal, and that she would like to pursue her claim. On January 27, 2005, the DOL replied to Mrs. F., stating that she could request modification of the June 2, 2004 dismissal. On February 28, 2005, the District Director granted Mrs. F.'s request for modification. The District Director referred the case to OALJ on March 30, 2005.

Over Claimant's Motion to Continue and pursuant to a Notice of Hearing dated August 8, 2005, I conducted a hearing on October 25, 2005 in Carbondale, Illinois, with Mrs. F., her new attorney, Mr. Dunham, and Ms. Conlin present.

Evidentiary Discussion

During my adjudication of this modification request, I identified several evidentiary issues that need to be addressed.

³According to 20 C.F.R. § 725.466(a), "dismissal of a claim shall have the same effect as a decision and order disposing of the claim on its merits."

First, at the hearing I left the record open for Mrs. F. to submit Mr. F.'s April 22, 1994 deposition. I received this deposition on November 1, 2005 and I admit it as CX 8.

Second, when this claim was forwarded to OALJ it included Mr. F.'s living miner claims in DX 1. Since then, in *Church v. Kentland Coal Corp.*, BRB Nos. 04-0617 and 04-0617A BLA (Apr. 8, 2005) (unpub.), the BRB stated that medical evidence from a miner's claim is not automatically admissible in the related survivor's claim. Instead, the survivor must specifically identify the medical evidence from the deceased miner's prior claims. Additionally, such evidence is also subject to the evidence limitations under 20 C.F.R. § 725.414. Despite the extensive amount of relevant medical evidence that may be contained in earlier DOL-sponsored medical evaluations of a deceased miner, and even though miner's prior claims and the associated medical evidence are automatically considered part of the record in his subsequent black lung disability claim under 20 C.F.R. § 725.309(d)(1) and not subject to the evidentiary limits under 20 C.F.R. § 725.414, the medical evidence contained in DX 1 is no longer automatically part of Mrs. F.'s survivor claim.

Third, during the initial presentation of a survivor claim, a claimant may submit two chest x-ray interpretation as case-in-chief evidence under 20 C.F.R. § 725.414(a)(2)(i) and Mrs. F. submitted two interpretations. However, I now recognize that because Mrs. F.'s claim is before me as a modification request, an additional evidentiary restriction is also applicable. According to 20 C.F.R. § 725.310(b), in a modification proceeding a party may only offer one additional chest x-ray interpretation. Although treatment records are excluded from this restriction, neither of the chest x-ray interpretations offered by Mrs. F. were done in the course of treatment. As result, I must exclude one of the two chest x-ray interpretations. The first x-ray interpretation (CX 1) was done on March 25, 1993, based on an x-ray dated November 17, 1992, with positive findings of pneumoconiosis, type p/q opacities, and a profusion of 1/1. The second x-ray interpretation (CX 2) was done on May 4, 1994, based on an x-ray dated July 28, 1993, with positive findings of pneumoconiosis, type p/s opacities, and a profusion of 1/2. Both physicians interpreting the x-rays were dually-qualified, and their findings were nearly the same. Because pneumoconiosis is a progressive disease, I find that the interpretation of the more recent chest x-ray should be admitted. Therefore I exclude CX 1 and admit CX 2.

Fourth, the Employer also submitted two chest x-ray interpretations at the hearing. Since the modification evidence restriction applies to all parties, I must also remove one of the Employer's radiographic studies from the record. The two interpretations submitted by the Employer were of the same chest x-ray, dated April 2, 1984. Both interpretations by similarly well qualified radiologists were negative. Because the Employer admitted EX 1 first, I admit EX 1 and exclude EX 2.

Fifth, Dr. Tuteur's December 2003 medical report (EX 4) raises an evidentiary issue because as part of his evaluation Dr. Tuteur also considered evidence not admitted into the record of Mrs. F.'s survivor claim. Specifically, besides considering the admitted evidence from Mr. F.'s medical record and the pathology findings, Dr. Tuteur also reviewed objective medical evidence obtained during Mr. F.'s earlier claims, which, as noted above, are not admitted as part of Mrs. F.'s survivor claim. Although Dr. Tuteur's comprehensive review certainly makes sound

medical sense, the evidentiary restrictions imposed by DOL, as interpreted by the BRB in *Church v. Kentland Coal Corp*, renders such a comprehensive study a mistake legal-wise.

Dr. Tuteur's consideration of the inadmissible evidence from prior exams of Mr. F. is problematic because under 20 C.F.R. §§ 725.414(a)(2)(i) and 3(i) "any chest X-ray interpretation, pulmonary function test results, blood gas studies . . . and physician opinions that appear in a medical report must each be admissible" under the regulations. In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006) (en banc), when confronted with a medical opinion that contained evidence not admitted into the formal record, the BRB indicated that an ALJ may: a) exclude the report, b) redact the objectionable content, c) require a revised report, or d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report. In this case, I will apply a combination of the second and fourth options. I will not use the objectionable content referenced by Dr. Tuteur in the adjudication of Mrs. F.'s survivor claim and I will consider the probative value of Dr. Tuteur's assessment based in part on the extent to which he relied upon the inadmissible evidence.

In his summary of Mr. F.'s medical history, Dr. Tuteur also referred to several pieces of information that are not included in the record and therefore also must be redacted from his report. Dr. Tuteur noted that from a "cardiorespiratory standpoint," Mr. F. had little exercise limitation and felt that he could have worked beyond age 65. After his stroke, Mr. F. became more exercise-intolerant but was able to walk one-half mile, though climbing stairs was difficult. At age 80, Mr. F. reported feeling "tired out," and a daily cough was often accompanied by yellow or black-streaked sputum. Mr. F. wheezed or had chest pain rarely. Mr. F. was prescribed a theophylline preparation for his pulmonary problems. Dr. Tuteur did not explain where this information came from, and I am unable to locate it elsewhere in the record. Dr. Tuteur also refers to arterial blood gas studies and pulmonary function tests done in 1984 and 1992, none of which are in the record in this claim. With regard to the results of the 1984 and 1992 pulmonary function tests, Dr. Tuteur concludes that they would be expected in someone with heart and vascular disease. I redact this conclusion because the evidence upon which it is based is not included in the record.

Similarly, Dr. Tuteur refers to 32 interpretations of 14 chest x-rays spanning from 1977 to 1994, but the 5 chest x-rays admitted in this claim begin in 1984. This discrepancy is problematic because Dr. Tuteur relies on the whole of those interpretations to make his conclusions that 1) although some reviewers noted the presence of coal workers' pneumoconiosis, the rest overwhelmingly indicated a lack of coal workers' pneumoconiosis, 2) the x-rays demonstrate a "waxing and waning" of infiltrates in the lower lung, and 3) the x-rays were "not always totally free of plate-like atelectasis." I redact these conclusions because the evidence upon which they are based is not entirely included in the record.

Dr. Tuteur also refers to Mr. F.'s childhood pneumonia in 1917 as a contributing factor to his chronic bronchitis, explaining that the massive U.S. 1917 flu epidemic caused death in the very young and very old, and left survivors with "airways abnormalities not infrequently developed." I was unable to locate any discussion of this condition elsewhere in the record in this claim, so I redact this information from Dr. Tuteur's report.

Returning to the *Harris* probative value assessment, although I am redacting the portions of Dr. Tuteur's report discussed above, which corrects the evidentiary problem, I find Dr. Tuteur's report does not lose probative value. Although he reviewed many medical reports, tests, and information that are not in the record in this claim, Dr. Tuteur's principal findings regarding Mr. F.'s death remain probative since he addressed that issue based on the admitted medical tests, medical treatment records, autopsy report, and Dr. Askin's report in particular.

Therefore, my decision in this case is based on the hearing testimony and the following documentary evidence: DX 1 (excluding medical evidence), DX 2 to DX 26, CX 2 to CX 8, and EX 1, EX 3 and EX 4.

ISSUE

Whether in filing a modification request, Mrs. F. demonstrated that a mistake in determination of fact occurred in the denial of her survivor claim on June 2, 2004.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the October 25, 2005 hearing, the parties stipulated: a) Mr. F. engaged in post-1969 coal mine employment, b) Mr. F. had at least 22 years of coal mine employment, c) Mrs. F. is an eligible survivor under the Act, and d) Freeman United Coal Mining Co. is the responsible operator (TR, pp.10-12).

Preliminary Findings

Born on August 4, 1911, Mr. F. married Mrs. F. on September 5, 1970. Mr. F. started working around coal mines in 1935. He started in the preparation plant, separating coal from rock, and after two years he moved to the water treatment plant, carrying 50 and 100 pound bags of treatment chemicals. He also worked every other weekend removing coal dust from the plants, and during the cold season (October-April) he worked in the scale house. He also delivered parts to underground miners, though he did not engage in underground mining himself. In 1955 he switched mines and used a broom and shovel to remove coal dust from the plants. Mr. F. retired in 1977 at age 65.⁴ Mr. F. smoked cigarettes at the rate of one-half pack per day from about age 18 to about age 51. Mr. F. passed away on June 22, 1994. (DX 10, DX 11, and CX 8)

Modification

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310(a). Upon the showing of a "change in conditions" or a "mistake in a determination of fact," the terms of an award or the decision to deny benefits may be reconsidered. 20 C.F.R. § 725.310. An order issued at the conclusion of a modification

⁴While working for the coal mines, Mr. F also played semi-pro baseball until his early 30s.

proceeding may terminate, continue, reinstate, increase, or decrease benefit payments or award benefits.

Since the present modification request relates to Mrs. F.'s survivor claim, evaluation of the record for a change in conditions is not warranted.⁵ Instead, the focus in modification proceedings in a survivor claim concerns a mistake of fact analysis. In *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971), the United States Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the administrative law judge is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." See also *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987).

My determination of whether a mistake in determination of fact occurred during the prior adjudication of Mrs. F.'s survivor claim involves the four entitlement elements that a claimant must prove by a preponderance of the evidence to receive survivor benefits under the Act and 20 C.F.R. § 718.205(a). The claimant bears the burden of establishing these elements by a preponderance of the evidence. If the claimant fails to prove any one of the requisite elements, the survivor claim for benefits must be denied. See *Gee v. W. G. Moore and Sons*, 9 B.L.R. 1-4 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985).

First, the claimant must establish eligibility as a survivor. A surviving spouse may be considered eligible for benefits under the Act if she was married to, and living with, the coal miner at the time of his death, and has not remarried.⁶

Second, the claimant must prove the coal miner had pneumoconiosis.⁷ "Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.⁸ The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."⁹ The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or

⁵Because Mr. F. passed away in 1994, there can be no change in conditions concerning his pulmonary condition since the denial of Mrs. F.'s survivor claim in 2004.

⁶20 C.F.R. § 718.4 indicates that the definitions in 20 C.F.R. § 725.101 are applicable. 20 C.F.R. § 725.101, in turn, refers to the term "survivor" as used in Subpart B of Part 725. 20 C.F.R. § 725.214 then sets out the spousal relationship requirements and 20 C.F.R. § 725.215 describes the dependency rules. According to § 725.214(a) the spousal relationship exists if the relationship is a valid marriage under state law. Under § 725.215(a), a spouse is deemed dependent if she was residing with the miner at the time of his death.

⁷20 C.F.R. § 718.205(a)(1); see *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

⁸20 C.F.R. § 718.201(a).

⁹20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

substantially aggravated by, dust exposure in coal mine employment.”¹⁰ As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

Third, once a determination has been made that a miner had pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.¹¹

Fourth, the surviving spouse has to demonstrate the coal miner's death was due to pneumoconiosis.¹²

Eligible Survivor

Based on the parties' stipulation and her hearing testimony, I find that Mrs. F. is an eligible survivor under the Act.

Presence of Pneumoconiosis

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (20 C.F.R. § 718.202 (a) (1)), autopsy or biopsy report (20 C.F.R. § 718.202(a)(2)), regulatory presumption (20 C.F.R. § 718.202(a)(3)),¹³ and medical opinion (20 C.F.R. § 718.202(a)(4)). Since the record does not contain evidence that Mr. F. had complicated pneumoconiosis and Mrs. F. filed her claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, Mrs. F. must rely on chest x-rays, autopsy evidence, and medical opinions to establish the presence of pneumoconiosis in her husband's lungs.

¹⁰20 C.F.R. § 718.201(b).

¹¹20 C.F.R. §§ 718.203(a) and 205(a)(2).

¹²20 C.F.R. § 718.205(a)(3).

¹³If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-Rays

The following table summarizes all chest x-ray interpretations admitted into evidence in this modification proceeding:

Date of x-ray	Exhibit	Physician	Interpretation
Apr. 2, 1984	EX 1	Dr. Scott, B, BCR ¹⁴	Negative for pneumoconiosis. No evidence of silicosis or coal workers' pneumoconiosis.
July 28, 1993	CX 2	Dr. Mathur, B, BCR	Positive for pneumoconiosis, profusion category 1/2, ¹⁵ type p/s opacities. ¹⁶
Apr. 21, 1993	DX 1 ¹⁷	Dr. Khan	Positive for coal workers' pneumoconiosis and COPD. Hypertranslucency, moderate interstitial pulmonary fibrosis. Prominent pulmonary blood vessels due to pulmonary hypertension. Increased interstitial fibrosis in both lower lobes.

¹⁴The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202(a)(1)(ii).

¹⁵The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102(b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

¹⁶There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, *RESPIRATORY DISEASES* 581 (3d ed. 1981).

¹⁷The three interpretations by Dr. Khan are admissible because they were part of Mr. F.'s treatment record. 20 C.F.R. § 725.414(a)(4). DX 1 contains chest x-ray interpretations that the Employer could use to rebut the treatment record, but a recent decision precludes admission of evidence rebutting treatment records. *See Henley v. Cowin & Co.*, BRB No. 05-0788 (May 30, 2006).

May 3, 1994	CX 5	Dr. Khan	(Negative for pneumoconiosis.) ¹⁸ Heart could be minimally enlarged. Lungs poorly aerated due to poor inspiratory effort. Minimal linear infiltrate in the right lung base and possibly the left. Scarring with possible discoid atelectasis. Rest of the lung fields clear. Thoracic aorta is atherosclerotic and dilated.
June 11, 1994	CX 5	Dr. Khan	(Negative for pneumoconiosis.) Bilateral basilar pulmonary congestion, poor inspiratory effort, moderate cardiomegaly. Congestive heart failure.

Based on the undisputed interpretations, three of the five chest x-rays, April 2, 1984, May 3, 1994, and June 11, 1994, are negative for pneumoconiosis. The other two films, July 28, 1993 and April 21, 1993 are positive for pneumoconiosis. Since three of the five chest x-rays are negative, the preponderance of the radiographic evidence is negative. Mrs. F. is unable to establish the presence of pneumoconiosis in Mr. F.'s lungs through radiographic evidence under 20 C.F.R. § 718.202(a)(1).¹⁹

Although Mrs. F. cannot establish the presence of black lung disease through chest x-ray evidence, she may still prove this requisite element of entitlement through autopsy reports or medical opinion.

Autopsy Evidence

(Note: the following summary of the autopsy findings, and other portions of this decision, contain detailed information concerning Mr. F.'s death submitted to support Mrs. F.'s survivor claim. While respecting the dignity and privacy of the deceased, some discussion of the detailed observations is nonetheless necessary because I find the medical information relevant to determine whether Mr. F. had pneumoconiosis.)

Prior to summarizing the autopsy report, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on a biopsy or autopsy is helpful. The regulation at 20 C.F.R. § 718.201(a)(1) defines "clinical" pneumoconiosis as a condition:

characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, and silicotuberculosis arising out of coal mine employment.

¹⁸Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. *See Marra v. Consolidation Coal Co.* 7 B.L.R. 1-216, 1-219 (1985).

¹⁹The inconclusive nature of the radiographic evidence in this case is best illustrated by Dr. Kahn's three interpretations. Although he reported the presence of pneumoconiosis in the April 21, 1993 chest x-ray, he did not report the presence of black lung disease in the subsequent films from May 3, 1994 and June 11, 1994.

Consequently, because the regulatory definition of clinical pneumoconiosis requires both a deposit of coal dust matter and lung tissue reaction to the deposit, an autopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202(a)(2).

Dr. Mina Amozis Gabrawy
(CX 6)

On June 22, 1994, Dr. Gabrawy, board certified in anatomic and clinical pathology,²⁰ conducted a chest-only autopsy of Mr. F. Upon gross examination of the heart, Dr. Gabrawy found that it weighed 580 grams, with a left ventricle width of 1 to 1.7 cm and a right ventricle width of 0.5 cm. The coronary walls were thickened by calcified atheromatous plaques bilaterally. The left lung weighed 480 grams, and the right lung weighed 660 grams. Brownish mucosa lined the trachea and main bronchi. Peripheral thromboemboli were noted in the right lung, and a wedge-shaped semifirm noncrepant segment was noted involving the right lower lung. The lung parenchyma was semicrepantent reddish grey, and the hilar nodes were dark gray-tan.

Under the microscope, Dr. Gabrawy saw moderate atherosclerosis in sections of the left coronary artery with thickening of the wall and calcification, and marked atherosclerosis with focal ossification and marked narrowing of the lumen in the left circumflex artery. The right coronary artery displayed thickening of the arteriole wall with narrowed lumen, fibrinous deposits, and focal calcification. The myocardium displayed scarring with young collagenous fibers and infiltrates of lymphocytes, a few plasma cells, and histiocytes with hemosiderin cytoplasmic pigment granules. Dr. Gabrawy noted organizing thrombus and areas of recent ischemia. Infiltrates of small numbers of lymphocytes involved the epicardium, and fatty infiltration was noted in the sinoatrial node region.

Lung sections displayed moderate alveolar edema and congestion. Dr. Gabrawy noted small amounts of black pigment granules in the alveolar septa and the peribronchial and perivascular stroma collagenous fibers. Dilated air spaces were seen with occasional floating septa. Sections of the right and left lower lobes displayed peripheral thromboemboli with organization in the right lower lobe displaying a peripheral segment infarct. A granuloma was noted in sections of the right upper lobe. Hilar nodes displayed black pigment granules with fibrosis partially replacing the nodal parenchyma. Sections of the bronchi displayed focal infiltrates of lymphocytes and a few plasma cells involving the submucosa. An occasional small macule was seen within the lung parenchyma.

Based on her evaluation, Dr. Gabrawy diagnosed 1) moderate to marked coronary atherosclerosis, 2) bilateral, peripheral pulmonary thromboemboli, 3) panlobular pulmonary emphysema, and 4) mild anthracosilicosis.

²⁰I take judicial notice of Dr. Gabrawy's board certification and have attached the certification documentation.

Dr. Frederic B. Askin
(EX 3)

On November 11, 2003, Dr. Askin, board certified in anatomic pathology, reviewed Dr. Gabrawy's report and microscopic slides of heart (16 slides) and lung (19 slides) tissue from Mr. F.'s autopsy.

The heart slides displayed scarring, evidence of an old infarction and ischemia. There were acute changes and mural thrombi attached to the endocardial surface in several sections. Extensive sampling showed that the coronary system was markedly atherosclerotic with significant narrowing of the lumen or the coronary arterial system.

The lung slides revealed numerous organizing thromboemboli in the pulmonary arterial system. One relatively recent thrombus was seen and it was associated with hemorrhagic infarction of the lung. Pulmonary edema was seen in the lung, as shown by pink fluid in the alveolar spaces. Dr. Askin saw scattered dust pigment throughout the lung and subpleural surfaces. The dust accumulated around respiratory bronchioles and formed scattered dust macules. A single, 2 mm dust micronodule was seen, but no stellate or silicotic nodules were seen. Dr. Askin noted a single hyalinized old granuloma near one bronchus, 3 mm at its greatest diameter, and most likely of infectious origin. The lung contained mild centrilobular emphysema. There was no parenchymal interstitial fibrosis or pleural plaques. "Examination of the modest number of macules . . . revealed minimal to no fibrosis." Refractile particles were scattered through the pigmented dust, but silicotic nodules were not present. Dr. Askin stated that the mere presence of refractile dust particles cannot be taken as evidence of silicosis. "The histologic findings would be consistent with mild Coal Worker's Pneumoconiosis in the proper occupational setting."

Dr. Askin observed that the significant findings were related to coronary artery disease, heart disease with cardiac hypertrophy, and pathologic evidence of pulmonary edema and the presence of an infarct in the lung, which suggests heart failure. Dr. Askin noted that "[n]ot all pulmonary emboli cause infarcts in the lung," but when "infarction does occur with a pulmonary embolus, there is usually some other abnormality, usually heart failure." Dr. Askin did not find anything in the slides to indicate that coal workers' pneumoconiosis played a role in or hastened Mr. F.'s death.

Discussion

Under the microscope, Dr. Gabrawy observed black pigment granules associated with fibrotic replacement of lung tissue, supportive of her diagnosis of anthracosilicosis. Similarly, Dr. Askin's microscopic observation of scattered coal dust macules and minimal fibrosis warrant his conclusion that mild coal workers' pneumoconiosis was present. Accordingly, Mrs. F. has shown the presence of coal workers' pneumoconiosis through autopsy evidence under 20 C.F.R. § 718.202(a)(2).

Pneumoconiosis Arising Out of Coal Mine Employment

After a survivor has proven the existence of pneumoconiosis, the next element is whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment. Ten years or more of coal mine employment qualifies for a rebuttable presumption that pneumoconiosis arose out of such employment. 20 C.F.R. § 410.456. At the hearing, the parties stipulated that Mr. F. worked at least 22 years as a coal miner. As a result, Mrs. F. may invoke the rebuttable presumption.

Upon consideration of the entire record, I find insufficient evidence to rebut the presumption. Accordingly, in the absence of contrary evidence, I find that Mr. F. had coal workers' pneumoconiosis.

Death Due to Pneumoconiosis

With the first three elements of entitlement proven (eligible survivor, presence of pneumoconiosis, and pneumoconiosis arising out of coal mine employment), Mrs. F. may receive survivor benefits only if the preponderance of the evidence in the record establishes that her husband's death was due to coal workers' pneumoconiosis. For a survivor claim filed on or after January 1, 1982, DOL regulations provide four means to establish that a coal miner's death was due to coal workers' pneumoconiosis:²¹

1. The miner had complicated pneumoconiosis;²²
2. Death was caused by pneumoconiosis;
3. Death was caused by complications of pneumoconiosis; or,
4. Pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. Notably, pneumoconiosis is deemed to be a substantially contributing cause of a miner's death if it hastens the miner's death.²³

Additionally, a survivor may not receive benefits if the coal miner's death was caused by traumatic injury, or the principal cause of death was a medical condition not related to pneumoconiosis, unless evidence establishes that pneumoconiosis was a substantially contributing cause of death.

²¹20 C.F.R. §§ 718.205(c)(1)-(3), 718.304.

²²According to 20 C.F.R. § 718.304, if a miner had complicated pneumoconiosis, an irrebuttable presumption exists that his death was due to pneumoconiosis.

²³20 C.F.R. § 718.205(c)(5). Prior to publication of the new regulations, the U.S. Court of Appeals for the Seventh Circuit, like other federal circuits, interpreted "substantially contributing cause" to include a hastening of a miner's death. *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992). Under this interpretation, any acceleration of the miner's death that is attributable to pneumoconiosis will entitle a claimant to survivor benefits.

Complicated Pneumoconiosis

As previously discussed, upon consideration of the entire medical record, including the probative autopsy/biopsy evidence, I determined Mr. F. did not have complicated pneumoconiosis. As a result, Mrs. F. cannot establish death due to pneumoconiosis under 20 C.F.R. § 718.304.

*Death Caused by Pneumoconiosis &
Death Caused by Complications of Pneumoconiosis*

None of the physicians concluded that coal workers' pneumoconiosis directly killed Mr. F. Likewise, no medical opinion supports a conclusion that direct complications of pneumoconiosis caused Mr. F.'s death.

Pneumoconiosis Was a Substantially Contributing Cause Of, Or Hastened, Death

Even though neither pneumoconiosis nor its complications caused Mr. F.'s death and he did not have complicated pneumoconiosis, Mrs. F. may still be entitled to survivor benefits if pneumoconiosis was a substantially contributing cause of her husband's death. Prior to publication of the new regulations, the U.S. Court of Appeals for the Fourth Circuit, like several other federal appellate circuits, interpreted "substantially contributing cause" to include a hastening of a miner's death in any way. *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 980 (4th Cir. 1992) and *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996). Adopting that standard, the new regulation, 20 C.F.R. § 718.205(c)(5), states "pneumoconiosis is 'a substantially contributing cause' of a miner's death if it hastens the miner's death." Under this legal standard, if pneumoconiosis cut short Mr. F.'s life in any manner, Mrs. F. may prevail with her modification request and survivor claim. Prior to assessing the role coal workers' pneumoconiosis played in Mr. F.'s death, I will summarize the remaining medical evidence in the record.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre²⁴ post²⁵	FVC pre post	MVV pre post	% FEV¹/FVC pre post	Qualified²⁶ pre post
CX 4	April 21, 1993 Dr. Khan ²⁷	81 66"	1.68 --	2.46 --	30 --	68.3%	No ²⁸

²⁴Test result before administration of a bronchodilator.

²⁵Test result following administration of a bronchodilator.

²⁶Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, and either the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%. Table B1 sets out the qualifying FEV1 values, but the values do not extend past age 71. However, the qualifying FEV1 values decrease as age increases, so I will infer qualifying results based on the age 71 values.

CX 3	July 28, 1993 Dr. Selby	81 65"	1.83 ²⁹ 1.72	2.93 3.29	20 30	62.5% 52.3%	No ³⁰ No
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Dr. Selby commented that Mr. F. had a moderate obstructive lung defect, confirmed by decreased flow rates. Lung volumes and diffusion capacity were normal. Poor test performance indicated by volume extrapolation/FVC. "This is interpreted as a significant response to bronchodilator."

Dr. Khan noted that "[t]hese Pulmonary Function Test suggest Restrictive Lung Disease such as Emphysema and Coal Miners' Pneumoconiosis."

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ₂ (rest) pCO ₂ (exercise)	pO ₂ (rest) pO ₂ (exercise)	Qualified ³¹
CX 4	April 21, 1993 Dr. Khan ³²	36.6	73.8	No ³³
CX 5	May 1994 ³⁴ Dr. Khan	34.8	71.8	No ³⁵

Dr. Saeed A. Khan
(CX 5 and CX 7)

Dr. Khan, board certified in internal medicine, was Mr. F.'s family doctor.³⁶ Dr. Khan examined Mr. F. on April 21, 1993.³⁷ Mr. F. was a retired coal miner with 42 years on top of the

²⁷This is admitted as a treatment record.

²⁸The qualifying FEV1 value for age 81 and 66" is 1.57.

²⁹The "Best" values were used for all of these results.

³⁰The qualifying FEV1 value for age 81 and 65" is 1.48.

³¹To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO₂ level, the value of the coal miner's pO₂ must be equal to or less than corresponding pO₂ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

³²Although Mr. F.'s treating physician conducted this study, it appears that it was done in preparation for one of Mr. F.'s living miner claims since a hand-written note says "ABG for BL." However, the study remains admissible as Mrs. F.'s one permissible arterial blood gas study on modification.

³³For the pCO₂ of 37, the qualifying pO₂ is 63 or less.

³⁴The arterial blood gas study results were reported in Dr. Khan's treatment notes in CX 5. The date of the study was sometime between May 14, 1994 and May 25, 1994.

³⁵For the pCO₂ of 35, the qualifying pO₂ is 65 or less

³⁶CX 8, p.34 (deposition of Mr. F.).

coal mines. He had a half-pack to 1-pack a day cigarette history for 40 years until he quit in 1962. Mr. F.'s medical history included hypertension, left-sided stroke, severe osteoarthritis, and chronic gouty arthritis. Mr. F. experienced shortness of breath on slight exertion, and coughed up mucorpulent, and occasionally dark, sputum daily. Upon physical exam, Mr. F. had a blood pressure of 128/80, pulse 60. His heart was slightly enlarged and he had an S4 gallup, loud P2 due to pulmonary hypertension. He had reduced breath sounds, bilateral dry crepitations, and bilateral scattered rhonchi. A chest x-ray showed moderate interstitial fibrosis in both lungs, hypertranslucency in the upper lobes, and increased pulmonary fibrosis in the lower lobes. Dr. Khan wrote that these findings were consistent with moderate coal workers' pneumoconiosis and moderate emphysema. An arterial blood gas study showed low oxygen levels, which suggested pulmonary emphysema and coal workers' pneumoconiosis. The pulmonary function test suggested restrictive lung disease consistent with coal workers' pneumoconiosis and pulmonary emphysema. Mr. F. was totally disabled due to coal workers' pneumoconiosis and pulmonary emphysema. He was "not a suitable candidate to work in the coal mines due to further deterioration of his breathing problems."

Dr. Khan saw Mr. F. on April 28, 1994 for chest pain and pressure radiating to the left arm. Mr. F. had a history of hypertension since 1983, a left-sided stroke in 1982, and a history of obesity, generalized atherosclerosis and chronic obstructive pulmonary disease ("COPD"). Mr. F. stopped smoking in his early 40s. Upon physical exam, Mr. F. had a blood pressure of 150/85, pulse 72. Dr. Khan heard vesicular breathing, dry crepitations, and occasional rhonchi.

Mr. F. was admitted to the emergency room ("ER") and then the intensive care unit ("ICU") between April 28, 1994 and May 2, 1994. Dr. Khan's diagnosis was acute myocardial infarction, arteriosclerotic heart disease, benign hypertension, osteoarthritis, COPD, possible coal miner's pneumoconiosis, chronic gouty arthritis, status-post cholecystectomy in 1988, old left-sided stroke in 1982, and status-post cataract surgery. The electrocardiogram ("EKG") showed a heart rate of 64 with normal sinus. The echocardiogram showed a reduced ejection fraction with ischemic cardiomyopathy. The heart was enlarged. A chest x-ray³⁸ showed no active lung disease, but moderate interstitial fibrosis "most probably due to coal miner's pneumoconiosis," cardiomegaly, and aortic atherosclerosis. Mr. F. was discharged in satisfactory condition on May 11, 1994.

Mr. F. was admitted to the ER and then the ICU on May 14, 1994. Mr. F. was weak and nauseous, had been feeling sick for the last two days, and was experiencing chest pain and epigastric pain. Upon physical exam, Dr. Khan noted that Mr. F. was dyspneic, cyanotic, and diaphoretic. Mr. F. had vesicular breathing, dry crepitations, and occasional rhonchi. The EKG showed ST segment depression, which improved. The chest x-ray showed "moderate interstitial pulmonary fibrosis without active lung disease and aortic atherosclerosis." The fibrosis "could be due to coal miner's pneumoconiosis as [Mr. F.] is a retired coal miner." A May 3, 1994 chest x-ray showed minimal infiltrate in the base of the right, and possibly the left, lung. Dr. Khan

³⁷That same day Dr. Khan wrote a letter to an attorney at the Southern Illinois University Legal Clinic on Mr. F.'s behalf. This report is admitted as Mrs. F.'s one medical report under 20 C.F.R. § 725.310(b). I summarize it here, instead of under a separate heading, for continuity.

³⁸Date unknown.

saw scarring with possible discoid atelectasis. The rest of the lung fields were clear. The diagnosis was acute myocardial ischemia due to arteriosclerotic heart disease, recent myocardial infarction, COPD, probable coal miner's pneumoconiosis, congestive heart failure, essential hypertension since 1985, osteoarthritis, and old cerebrovascular accident in 1982. Mr. F. was discharged in satisfactory condition on May 25, 1994.

Mr. F. was admitted to the ER on May 29, 1994, complaining of chest pain and pressure, weakness, and lethargy. Mr. F.'s vision was blurred, he was unable to walk, and he had numbness and tingling in both feet. Blood pressure was 90/40, but it came up to 102/80. Pulse 68. Upon physical exam, Mr. F. had vesicular breathing, dry crepitations, and occasional rhonchi. Mr. F. had renal failure, dull abdominal pain, poor peripheral circulation, and his condition was deteriorating. Dr. Khan noted that Mr. F. had "a lot of pulmonary fibrosis due to his black lung and COPD."

In a consultation report to Dr. Khan on June 8, 1994, Dr. Mark A. Murfin stated that Mr. F. "does have COPD and coal miner's pneumoconiosis." Upon physical exam, the lungs were clear bilaterally.

A chest x-ray on June 11, 1994 showed bilateral basilar pulmonary congestion, poor inspiratory effort, moderate cardiomegaly, and congestive heart failure. In a consultation report on June 13, 1994, Dr. Sam Techo reported that Mr. F.'s lungs were congested bilaterally with crepitations in both lung bases and diminished breath sounds. Mr. F. was discharged on June 15, 1994.

On June 24, 1994, following an autopsy, Dr. Khan signed Mr. F.'s death certificate. According to the physician, Mr. F.'s death on June 22, 1994 was caused by myocardial infarction due to congestive heart failure due to pneumoconiosis.

Dr. Peter G. Tuteur
(EX 4)

On December 15, 2003, Dr. Tuteur, board certified in internal medicine and pulmonary disease, examined Mr. F.'s medical record. Mr. F. was 82 when he died due to acute myocardial infarction associated with extensive pulmonary emboli with infarction. Mr. F. was an aboveground coal miner for 42 years, working in the water plant and then a top laborer until 1977 when he was 65. Mr. F.'s time in the mines was long enough to produce coal workers' pneumoconiosis or other coal mine dust related diseases in a susceptible host. Mr. F. smoked from approximately 1931 to 1962, at the rate of half a pack to 1 pack per day, which placed him at risk for COPD, arteriosclerotic heart disease, and lung cancer.

Mr. F.'s biggest health problems were cardiovascular. Mr. F. had a family history of heart disease, and he developed hypertension that was treated successfully. In 1982 he suffered a left-sided stroke that left his ambulation difficult, and in 1984 and 1994 he developed an acute myocardial infarction with associated congestive heart failure. Mr. F.'s ambulation was also impaired by joint disease and gout.

Some physicians intermittently heard crackles and gurgles upon physical exam, but the most recent exams produced normal results. Pulmonary function tests were normal or nearly normal. MVV results were varied but normal when valid. The measurement of total lung capacity was normal. Six weeks before his death, Mr. F. had normal resting arterial blood gas results.

The autopsy performed on Mr. F. identified the myocardial infarction and congestive heart failure, and also bilateral pulmonary emboli with infarction. The prosector noted some emphysema and mild anthracosilicosis. Dr. Askin reviewed the autopsy results and noted the thromboembolic phenomenon, the advanced coronary artery disease, and the myocardial infarction. Dr. Askin also found subpleural pigment with scattered macules and one micronodule presumed to be of infectious origin. Dr. Askin noted mild centrilobular emphysema, saw no fibrosis, and diagnosed very mild coal workers' pneumoconiosis of no clinical significance.

Based on his review of the medical record, Dr. Tuteur concluded that "there is no convincing information that [Mr. F.] had more than very, very mild coal workers' pneumoconiosis on histologic examination." Accordingly, Mr. F. did not have sufficient coal workers' pneumoconiosis to "produce clinical symptoms, physical examination abnormalities, impairment of pulmonary function, and/or radiographic change." However, Mr. F. did have "extensive" cardiovascular disease shown by hypertension, cardiomegaly, acute myocardial infarction(s), and stroke. These conditions were unrelated to coal mine dust inhalation or coal workers' pneumoconiosis. Mr. F. died due to advanced and severe bilateral pulmonary emboli with infarction, in association with acute myocardial infarction; conditions unrelated to coal mine dust inhalation or coal workers' pneumoconiosis.

Mr. F.'s breathlessness was a "quintessential clinical feature" of coal workers' pneumoconiosis, but it was also consistent with "virtually any primary pulmonary or cardiac disorder." Mr. F. had cardiac and vascular processes that resulted in stroke, acute myocardial infarction with cardiomegaly, episodes of congestive heart failure, and "eventually well controlled" hypertension. Mr. F. also had cough and expectoration, which fulfills the World Health Organization definition of chronic bronchitis. The pulmonary function data was "essentially normal," which shows that his chronic bronchitis was without significant pulmonary function impairment. Mr. F. rarely wheezed or had chest pain. Cough, expectoration, wheezing, and chest pain are not regular features of coal workers' pneumoconiosis. When coal workers' pneumoconiosis produces pulmonary function impairment, one expects a restrictive abnormality shown through reduced total lung capacity and/or gas exchange impairment at exercise and then rest. These were not seen in Mr. F.'s case. With regard to the chest x-ray interpretations, coal workers' pneumoconiosis tends to produce symmetrical nodules in the upper lobes, but this was not seen in Mr. F.'s case.

Dr. Tuteur also noted that coal mine dust, even absent coal workers' pneumoconiosis, may produce a "clinical phenotype" similar to cigarette smoke-induced COPD. However, there is no anatomical or pathological evidence for that in Mr. F.'s case. Additionally, coal dust-induced COPD is "a relatively infrequent occurrence" compared to cigarette smoke-induced COPD. A smoker for over 30 years, Mr. F. had the symptoms of chronic bronchitis. Mr. F.'s

cough and expectoration was due to chronic inhalation of cigarette smoke, not coal dust. Mr. F.'s intermittent congestive heart failure may also be a contributing factor.

Discussion

In considering the numerous medical opinions, I first note that the treatment records and pulmonary evaluation pre-date Mr. F.'s death and provide no direct evidence on the cause of his death. Nevertheless, that medical evidence remains important because it establishes several significant aspects of Mr. F.'s health during his life, including a stroke in 1982, hypertension from 1983 onwards, and myocardial infarction in 1994.

Concerning cause of death, Dr. Gabrawy did not render a specific conclusion. Based on his autopsy review, after noting significant evidence of coronary artery disease and heart disease, Dr. Askin found insufficient evidence in the autopsy to suggest that Mr. F. died due to coal workers' pneumoconiosis. Dr. Khan concluded Mr. F.'s death was caused by myocardial infarction due to congestive heart failure due to pneumoconiosis. Dr. Tuteur determined that Mr. F. died due to advanced and severe bilateral pulmonary emboli with infarction, in association with acute myocardial infarction. Dr. Tuteur also opined that coal workers' pneumoconiosis did not play any role in Mr. F.'s death.

Due to the conflict in the medical reports, I must evaluate the relative probative value of the conflicting evidence in terms of documentation, reasoning, and consideration of inadmissible evidence. As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, I first note that as a treating physician,³⁹ Dr. Khan was well positioned to provide a probative assessment on the nature and extent of Mr. F.'s death. However, his terse conclusions on the death certificate have little probative value due to the absence of any explanation for his belief that coal workers' pneumoconiosis caused Mr. F.'s congestive heart failure which led to his fatal myocardial infarction. Dr. Khan's lack of explanation is profound in this case because the autopsy and pathology studies impeach the reasonableness of his death certificate statements. Significantly, while establishing the presence

³⁹Dr. Khan's status as Mr. F.'s treating physician does not automatically accord his findings greater probative weight than those of any other physician. *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001).

of only mild coal workers' pneumoconiosis, the autopsy reports indicated consistent with his history of hypertension and stroke that Mr. F. had moderate to marked coronary artery disease. Specifically, Dr. Gabrawy and Dr. Askin identified substantial thickening and calcification of the coronary arteries. In his silence, Dr. Khan has failed to address why he selected mild coal workers' pneumoconiosis rather than advanced coronary artery disease as the precipitating cause of, or a contributing factor to, Mr. F.'s congestive heart failure and fatal myocardial infarction.

In contrast, based on the specific findings of the autopsy, the opinion of Dr. Askin that coal workers' pneumoconiosis played no role in, and did not hasten, Mr. F.'s death is reasoned. Similarly, based on a well documented review, Dr. Tuteur presented reasoned conclusions that a) Mr. F.'s mild coal workers' pneumoconiosis was not a contributing factor in his death; and, b) Mr. F.'s death was due to advanced and severe bilateral pulmonary emboli with infarction, in association with acute myocardial infarction, which were unrelated to coal mine dust inhalation or coal workers' pneumoconiosis.

Consequently, I find the preponderance of the more probative medical opinions of Dr. Askin and Dr. Tuteur outweigh Dr. Khan's death certificate findings and establish that coal workers' pneumoconiosis was not a contributing factor to, and did not hasten, Mr. F.'s death.

CONCLUSION

Upon consideration of the entire medical record, including the medical opinions presented during the modification proceedings, I find no mistake of fact occurred in the initial denial of Mrs. F.'s survivor claim. Although Mrs. F. is an eligible survivor and Mr. F. had coal workers' pneumoconiosis, the preponderance of the more probative medical opinion establishes that neither coal workers' pneumoconiosis nor its complications caused, contributed to, or hastened the death of Mr. F. Accordingly, having failed to establish a requisite element of entitlement in a survivor claim, death due to pneumoconiosis, Mrs. F.'s modification request must be denied.

ORDER

The modification request to the survivor claim of MRS. V.F. is **DENIED**.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: December 13, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of

Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties
Certification:

Mina Amozis Gabrawy, MD

Certified by the American Board of Pathology in:

Anatomic Pathology & Clinical Pathology

American Board of Medical Specialties
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